FOR OHF USE

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2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0037762

Facility Name: ALBANY CARE INC

Address: 901 MAPLE (Number) EVANSTON (City) 60202 (Zip Code)

County: COOK

Telephone Number: (847) 475-4000 **Fax #** (847) 475-8316

IDPA ID Number: 363764987001

Date of Initial License for Current Owners: 11/01/91

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steve Lavenda **Telephone Number:** (847) 236 - 1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/01 to 12/31/01 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) _____

(Title) _____

Paid Preparer

(Signed) See Accountants' Compilation Report Attached (Date)

(Print Name and Title) CARY C. BUXBAUM, C.P.A.

(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C.
111 Pfingsten Road, Suite 300 Deerfield, IL 60015

(Telephone) (847) 236-1111 Fax# (847) 236-1155

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number ALBANY CARE INC # 0037762 Report Period Beginning: 01/01/01 Ending: 12/31/01

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	417	Intermediate (ICF)	417	152,205	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	417	TOTALS	417	152,205	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF	133,169	948	375	134,492	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	133,169	948	375	134,492	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 88.36%

D. How many bed-hold days during this year were paid by Public Aid?
2114 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/A

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 11/1/91

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date _____ NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [ ] NO [ ]

Tax Year: 12/31/01 Fiscal Year: 12/31/01

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number ALBANY CARE INC # 0037762 Report Period Beginning: 01/01/01 Ending: 12/31/01

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	251,889	53,758	64,140	369,787		369,787	(40,264)	329,523			1
2	Food Purchase		426,708		426,708	(14,892)	411,816	(30)	411,786			2
3	Housekeeping	223,680	39,739		263,419		263,419	1,138	264,557			3
4	Laundry		27,314	24,682	51,996		51,996		51,996			4
5	Heat and Other Utilities			244,559	244,559		244,559	4,082	248,641			5
6	Maintenance	60,244		171,451	231,695		231,695	(161,843)	69,852			6
7	Other (specify):*							7,564	7,564			7
8	**TOTAL General Services**	535,813	547,519	504,832	1,588,164	(14,892)	1,573,272	(189,353)	1,383,919			8
	B. Health Care and Programs											
9	Medical Director			2,400	2,400		2,400		2,400			9
10	Nursing and Medical Records	2,019,243	34,801	148,553	2,202,597		2,202,597	(45,585)	2,157,012			10
10a	Therapy	41,180		39,232	80,412		80,412	(10,933)	69,479			10a
11	Activities	426,111	19,462		445,573		445,573		445,573			11
12	Social Services	436,380			436,380		436,380		436,380			12
13	Nurse Aide Training											13
14	Program Transportation			4,227	4,227		4,227		4,227			14
15	Other (specify):*							12,551	12,551			15
16	**TOTAL Health Care and Programs**	2,922,914	54,263	194,412	3,171,589		3,171,589	(43,967)	3,127,622			16
	C. General Administration											
17	Administrative	142,488		855,154	997,642		997,642	(569,036)	428,606			17
18	Directors Fees											18
19	Professional Services			275,519	275,519	(19,504)	256,015	(152,369)	103,646			19
20	Dues, Fees, Subscriptions & Promotions			71,992	71,992		71,992	(11,156)	60,836			20
21	Clerical & General Office Expenses	299,913		189,032	488,945		488,945	(39,380)	449,565			21
22	Employee Benefits & Payroll Taxes			572,127	572,127	14,892	587,019	(21,360)	565,659			22
23	Inservice Training & Education											23
24	Travel and Seminar			3,947	3,947		3,947	(1,628)	2,319			24
25	Other Admin. Staff Transportation			7,900	7,900		7,900	1,448	9,348			25
26	Insurance-Prop.Liab.Malpractice			129,452	129,452		129,452	2,189	131,641			26
27	Other (specify):*							58,265	58,265			27
28	**TOTAL General Administration**	442,401		2,105,123	2,547,524	(4,612)	2,542,912	(733,027)	1,809,885			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,901,128	601,782	2,804,367	7,307,277	(19,504)	7,287,773	(966,347)	6,321,426			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number ALBANY CARE INC #0037762 Report Period Beginning: 01/01/01 Ending: 12/31/01

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			96,734	96,734		96,734	252,024	348,758			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			36,711	36,711		36,711	1,047,632	1,084,343			32
33	Real Estate Taxes			464,591	464,591	19,504	484,095	8,714	492,809			33
34	Rent-Facility & Grounds			1,738,491	1,738,491		1,738,491	(1,738,491)				34
35	Rent-Equipment & Vehicles			30,483	30,483		30,483	3,819	34,302			35
36	Other (specify):*							19,855	19,855			36
37	**TOTAL Ownership**			2,367,010	2,367,010	19,504	2,386,514	(406,447)	1,980,067			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			228,307	228,307		228,307		228,307			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			228,307	228,307		228,307		228,307			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,901,128	601,782	5,399,684	9,902,594		9,902,594	(1,372,794)	8,529,800			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number ALBANY CARE INC # 0037762 Report Period Beginning: 01/01/01 Ending: 12/31/01

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	5,706	30		9
10	Interest and Other Investment Income	(9,865)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(30)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(417)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(34,804)	21		24
25	Fund Raising, Advertising and Promotional	(3,599)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(35,376)	21		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(342)	20		28
29	Other-Attach Schedule	(177,933)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (256,660)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(1,116,134)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (1,116,134)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,372,794)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

ALBANY CARE INC

ID# 0037762

Report Period Beginning: 01/01/01

Ending: 12/31/01

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Illinois Council COPE	$ (7,328)	20	1
2	Prescription drugs-Veterans	(3,032)	10	2
3	Rental income (miscellaneous income)	(4,290)	35	3
4	Jury duty income (miscellaneous income)	(171)	10	4
5	Non-allowable legal expense	(19,337)	19	5
6	Non-allowable employee benefits	(14,760)	22	6
7	Capitalized R&M	(129,169)	6	7
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STATE OF ILLINOIS

Summary A

Facility Name & ID Number ALBANY CARE INC # 0037762 Report Period Beginning: 01/01/01 Ending: 12/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary					(40,264)							(40,264)	1
2	Food Purchase	(30)											(30)	2
3	Housekeeping			1,138									1,138	3
4	Laundry													4
5	Heat and Other Utilities			1,373	2,709								4,082	5
6	Maintenance	(129,169)		1,018	(24,243)	(9,449)							(161,843)	6
7	Other (specify):*				1,470	6,094							7,564	7
8	**TOTAL General Services**	(129,199)		3,529	(20,064)	(43,619)							(189,353)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(3,049)			(42,536)								(45,585)	10
10a	Therapy					(10,933)							(10,933)	10a
11	Activities													11
12	Social Services													12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*				7,456	5,095							12,551	15
16	**TOTAL Health Care and Programs**	(3,049)			(35,080)	(5,838)							(43,967)	16
	C. General Administration													
17	Administrative			26,223	(36,021)	(561,110)		1,872					(569,036)	17
18	Directors Fees													18
19	Professional Services	(19,337)		(142,721)	(17,979)	27,598		70					(152,369)	19
20	Fees, Subscriptions & Promotions	(11,686)		133	354			43					(11,156)	20
21	Clerical & General Office Expenses	(70,180)		83,183	13,744	(66,192)		65					(39,380)	21
22	Employee Benefits & Payroll Taxes	(14,760)				(6,600)							(21,360)	22
23	Inservice Training & Education													23
24	Travel and Seminar			191	581	(2,400)							(1,628)	24
25	Other Admin. Staff Transportation			1,076	6,372	(6,000)							1,448	25
26	Insurance-Prop.Liab.Malpractice			709	1,348			132					2,189	26
27	Other (specify):*			15,176	17,437	24,621		1,031					58,265	27
28	**TOTAL General Administration**	(115,963)		(16,030)	(14,164)	(590,083)		3,213					(733,027)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(248,211)		(12,501)	(69,308)	(639,540)		3,213					(966,347)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number ALBANY CARE INC # 0037762 Report Period Beginning: 01/01/01 Ending: 12/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	5,706	234,183	4,216	7,919								252,024	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(9,865)	1,048,250	1,870	7,377								1,047,632	32
33	Real Estate Taxes			2,565	6,149								8,714	33
34	Rent-Facility & Grounds		(1,738,491)										(1,738,491)	34
35	Rent-Equipment & Vehicles	(4,290)		4,363	9,891	(7,200)		1,055					3,819	35
36	Other (specify):*		19,855										19,855	36
37	**TOTAL Ownership**	(8,449)	(436,203)	13,014	31,336	(7,200)		1,055					(406,447)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	**TOTAL Special Cost Centers**													44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(256,660)	(436,203)	513	(37,972)	(646,740)		4,268					(1,372,794)	45

Facility Name & ID Number ALBANY CARE INC # 0037762 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See attached		See attached		See attached		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent	$ 1,738,491	Albany Care, LLC		$	$ (1,738,491)	1
2	V	36	Amortization		Albany Care, LLC		19,855	19,855	2
3	V	30	Depreciation		Albany Care, LLC		234,183	234,183	3
4	V	32	Interest		Albany Care, LLC		1,048,481	1,048,481	4
5	V	32	Interest		Albany Care, LLC		(231)	(231)	5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 1,738,491			$ 1,302,288	$ * (436,203)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number ALBANY CARE INC # 0037762 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	3	HOUSEKEEPING	$	PREFERRED BOOKKEEPING	100.00%	$ 1,138	$ 1,138	15
16	V	5	UTILITIES		PREFERRED BOOKKEEPING	100.00%	1,373	1,373	16
17	V	6	REPAIRS AND MAINT.		PREFERRED BOOKKEEPING	100.00%	1,018	1,018	17
18	V	17	ADMIN. FINANCIAL SAL.		PREFERRED BOOKKEEPING	100.00%	26,223	26,223	18
19	V	19	PROFESSIONAL FEES		PREFERRED BOOKKEEPING	100.00%	2,979	2,979	19
20	V	20	DUES,SUBSCRIPTIONS		PREFERRED BOOKKEEPING	100.00%	133	133	20
21	V	21	CLERICAL		PREFERRED BOOKKEEPING	100.00%	83,183	83,183	21
22	V	24	SEMINARS		PREFERRED BOOKKEEPING	100.00%	191	191	22
23	V	25	ADMIN. STAFF TRAVEL		PREFERRED BOOKKEEPING	100.00%	1,076	1,076	23
24	V	26	INSURANCE		PREFERRED BOOKKEEPING	100.00%	709	709	24
25	V	27	EMPLOYEE BENEFITS		PREFERRED BOOKKEEPING	100.00%	15,176	15,176	25
26	V	30	DEPRECIATION		PREFERRED BOOKKEEPING	100.00%	4,216	4,216	26
27	V	32	INTEREST		PREFERRED BOOKKEEPING	100.00%	1,870	1,870	27
28	V	33	REAL ESTATE TAXES		PREFERRED BOOKKEEPING	100.00%	2,565	2,565	28
29	V	35	EQUIPMENT RENTAL		PREFERRED BOOKKEEPING	100.00%	4,363	4,363	29
30	V								30
31	V								31
32	V	19	ACCOUNT./BOOKKEEPING	145,700	PREFERRED BOOKKEEPING	100.00%		(145,700)	32
33	V	19	COMPUTER	10,008	PREFERRED BOOKKEEPING	100.00%	10,008		33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 155,708			$ 156,221	$ * 513	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number ALBANY CARE INC # 0037762 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	$	S.I.R. MANAGEMENT, INC.	100.00%	$ 2,709	$ 2,709	15
16	V	6	REPAIRS AND MAINT.	37,536	S.I.R. MANAGEMENT, INC.	100.00%	13,293	(24,243)	16
17	V	7	EMP. BEN.-GEN. SERV.		S.I.R. MANAGEMENT, INC.	100.00%	1,470	1,470	17
18	V	10	NURSING	82,572	S.I.R. MANAGEMENT, INC.	100.00%	40,036	(42,536)	18
19	V	15	EMP. BEN.-H.C.		S.I.R. MANAGEMENT, INC.	100.00%	7,456	7,456	19
20	V	17	ADMINISTRATIVE	52,548	S.I.R. MANAGEMENT, INC.	100.00%	16,527	(36,021)	20
21	V	19	PROFESSIONAL FEES	32,487	S.I.R. MANAGEMENT, INC.	100.00%	14,508	(17,979)	21
22	V	20	FEES,SUBSCRIPTIONS		S.I.R. MANAGEMENT, INC.	100.00%	354	354	22
23	V	21	CLERICAL & GENERAL	42,540	S.I.R. MANAGEMENT, INC.	100.00%	56,284	13,744	23
24	V	24	EDUCATION & SEMINAR		S.I.R. MANAGEMENT, INC.	100.00%	581	581	24
25	V	25	OTHER ADMIN. STAFF TRANS.		S.I.R. MANAGEMENT, INC.	100.00%	6,372	6,372	25
26	V	26	INSURANCE		S.I.R. MANAGEMENT, INC.	100.00%	1,348	1,348	26
27	V	27	EMP. BEN.-GEN. ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	17,437	17,437	27
28	V	30	DEPRECIATION		S.I.R. MANAGEMENT, INC.	100.00%	7,919	7,919	28
29	V	32	INTEREST		S.I.R. MANAGEMENT, INC.	100.00%	7,377	7,377	29
30	V	33	REAL ESTATE TAXES		S.I.R. MANAGEMENT, INC.	100.00%	6,149	6,149	30
31	V	35	EQUIPMENT RENTAL		S.I.R. MANAGEMENT, INC.	100.00%	9,891	9,891	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 247,683			$ 209,711	$ * (37,972)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number ALBANY CARE INC # 0037762 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	DIETARY SALARIES	$ 42,540	S.I.R. MANAGEMENT, INC.	100.00%	$ 11,702	$ (30,838)	15
16	V	7	EMP. BEN.-DIETARY		S.I.R. MANAGEMENT, INC.	100.00%	2,202	2,202	16
17	V	17	ADMIN./LEGAL SALARIES	696,880	S.I.R. MANAGEMENT, INC.	100.00%	135,770	(561,110)	17
18	V	19	FINANCIAL CONSULTANT		S.I.R. MANAGEMENT, INC.	100.00%	27,598	27,598	18
19	V	27	EMP. BEN.-ADMINISTRATIVE		S.I.R. MANAGEMENT, INC.	100.00%	24,621	24,621	19
20	V								20
21	V								21
22	V	10A	SPECIAL REHAB	37,032	S.I.R. MANAGEMENT, INC.	100.00%	26,099	(10,933)	22
23	V	15	EMP. BEN.-HEALTH CARE & PROG.		S.I.R. MANAGEMENT, INC.	100.00%	5,095	5,095	23
24	V								24
25	V								25
26	V	6	REPAIRS AND MAINT.	11,808	S.I.R. MANAGEMENT, INC.	100.00%	7,759	(4,049)	26
27	V	7	EMP. BEN.-GEN. SERV.		S.I.R. MANAGEMENT, INC.	100.00%	1,515	1,515	27
28	V								28
29	V								29
30	V	1	DIETICIAN SALARIES	21,600	S.I.R. MANAGEMENT, INC.	100.00%	12,174	(9,426)	30
31	V	7	EMP. BEN.-GEN. ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	2,377	2,377	31
32	V	21	TELEPHONE & OFFICE	66,192	S.I.R. MANAGEMENT, INC.	100.00%		(66,192)	32
33	V	6	REPAIRS	5,400	S.I.R. MANAGEMENT, INC.	100.00%		(5,400)	33
34	V	35	EQUIPMENT RENTAL	3,000	S.I.R. MANAGEMENT, INC.	100.00%		(3,000)	34
35	V	35	AUTO LEASE	4,200	S.I.R. MANAGEMENT, INC.	100.00%		(4,200)	35
36	V	25	TRAVEL	6,000	S.I.R. MANAGEMENT, INC.	100.00%		(6,000)	36
37	V	24	SEMINARS	2,400	S.I.R. MANAGEMENT, INC.	100.00%		(2,400)	37
38	V	22	EMPLOYEE BENEFITS	6,600	S.I.R. MANAGEMENT, INC.	100.00%		(6,600)	38
39	Total			$ 903,652			$ 256,912	$ * (646,740)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number ALBANY CARE INC # 0037762 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	22	EMPLOYEE HEALTH INS.	$	CCS EMPLOYEE BENEFIT GROUP	100.00%	$ 101,091	$ 101,091	15
16	V								16
17	V								17
18	V								18
19	V	22	EMPLOYEE HEALTH INS.	101,091	CCS EMPLOYEE BENEFIT GROUP	100.00%		(101,091)	19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 101,091			$ 101,091	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number ALBANY CARE INC # 0037762 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	PROFESSIONAL FEES	$	ECM OWNERS COUNCIL	100.00%	$ 70	$ 70	15
16	V	20	DUES, FEES & SUBSCRIPTIONS		ECM OWNERS COUNCIL	100.00%	43	43	16
17	V	21	CLERICAL		ECM OWNERS COUNCIL	100.00%	65	65	17
18	V	26	INSURANCE		ECM OWNERS COUNCIL	100.00%	132	132	18
19	V	35	VEHICLE RENTAL		ECM OWNERS COUNCIL	100.00%	1,055	1,055	19
20	V	17	MANAGEMENT FEES	15,600	ECM OWNERS COUNCIL	100.00%		(15,600)	20
21	V	17	ADMIN. SAL. - M. GIANNINI		ECM OWNERS COUNCIL	100.00%	17,459	17,459	21
22	V	27	EMP. BEN. - M. GIANNINI		ECM OWNERS COUNCIL	100.00%	1,031	1,031	22
23	V	17	ADMIN. SALARY		ECM OWNERS COUNCIL	100.00%	13	13	23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 15,600			$ 19,868	$ * 4,268	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number ALBANY CARE INC # 0037762 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number ALBANY CARE INC # 0037762 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number ALBANY CARE INC # 0037762 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number ALBANY CARE INC # 0037762 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number ALBANY CARE INC # 0037762 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Patricia McDiarmid	Owner	Administrative	0.48%	See attached	10.68	21.36%	Alloc sal/SIR	$ 16,527	17-7	1
2	Louise Bergthold	Owner	Administrative	0.72%	See attached	11.75	21.36%	Alloc. Salary	39,424	17-7	2
3	Bryan Barrish	Executive Director	Administrative	14.63%	See attached	8.55	19.00%	All. Sal/mgmt	65,667	17-7&17-3	3
4	Mike Giannini	Owner	Administrative	7.31%	See attached	8.55	19.00%	All. Sal/mgmt	65,908	17-7&17-3	4
5	Tom Winter	Owner	Administrative	2.88%	See attached	10.12	16.80%	Alloc. Salary	26,223	17-7	5
6	Jeff Oravec	Owner	Administrative	0.48%	See attached	8.55	21.37%	Alloc. Salary	15,740	17-7	6
7	Arturo Rominiquit	Relative	Clerical	0	See attached	6.75	16.88%	Alloc. Salary	3,820	21-7	7
8	Nenita Guzman	Relative	Dietary	0	See attached	10.68	21.36%	Alloc. Salary	11,702	1-7	8
9	Eric Rothner	Owner	Administrative	4.55%	See attached	1.35	0.02%	All. Sal/mgmt	33,290	17-7&17-3	9
10	Dennis Tossi	Owner	Administrative	3.12%	See attached	40	100.00%	Facility salary	120,244	17-1	10
11											11
12											12
13								TOTAL	$ 398,545		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number ALBANY CARE INC # 0037762 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number ALBANY CARE INC # 0037762 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: PREFERRED BOOKEEPING SERVICES
Street Address: 4100 WEST PRATT AVE.
City / State / Zip Code: LINCOLNWOOD, IL. 60712
Phone Number: (847) 674-5200
Fax Number: (847) 674-5267

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	3	HOUSEKEEPING	BOOK./ACCNT.INCOME	863,792	11	$ 6,745	$	145,700	$ 1,138	1
2	5	UTILITIES	BOOK./ACCNT.INCOME	863,792	11	8,137		145,700	1,373	2
3	6	REPAIRS AND MAINT.	BOOK./ACCNT.INCOME	863,792	11	6,035		145,700	1,018	3
4	17	ADMIN. FINANCIAL SAL.	BOOK./ACCNT.INCOME	863,792	11	155,464	155,464	145,700	26,223	4
5	19	PROFESSIONAL FEES	BOOK./ACCNT.INCOME	863,792	11	17,663		145,700	2,979	5
6	20	DUES,SUBSCRIPTIONS	BOOK./ACCNT.INCOME	863,792	11	788		145,700	133	6
7	21	CLERICAL	BOOK./ACCNT.INCOME	863,792	11	493,157	432,172	145,700	83,183	7
8	24	SEMINARS	BOOK./ACCNT.INCOME	863,792	11	1,135		145,700	191	8
9	25	ADMIN. STAFF TRAVEL	BOOK./ACCNT.INCOME	863,792	11	6,379		145,700	1,076	9
10	26	INSURANCE	BOOK./ACCNT.INCOME	863,792	11	4,205		145,700	709	10
11	27	EMPLOYEE BENEFITS	BOOK./ACCNT.INCOME	863,792	11	89,973		145,700	15,176	11
12	30	DEPRECIATION	BOOK./ACCNT.INCOME	863,792	11	24,993		145,700	4,216	12
13	32	INTEREST	BOOK./ACCNT.INCOME	863,792	11	11,085		145,700	1,870	13
14	33	REAL ESTATE TAXES	BOOK./ACCNT.INCOME	863,792	11	15,206		145,700	2,565	14
15	35	EQUIPMENT RENTAL	BOOK./ACCNT.INCOME	863,792	11	25,868		145,700	4,363	15
16										16
17										17
18										18
19	19	COMPUTER	DIRECT ALLOCATION						10,008	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 866,833	$ 587,636		$ 156,221	25

Facility Name & ID Number ALBANY CARE INC # 0037762 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: S.I.R. MANAGEMENT, INC.
Street Address: 6840 N. LINCOLN
City / State / Zip Code: LINCOLNWOOD, IL. 60712
Phone Number: (847) 675 -7979
Fax Number: (847) 675 -0555

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	PATIENT DAYS	629,428	10	$ 12,680	$	134,492	$ 2,709	1
2	6	REPAIRS AND MAINT.	PATIENT DAYS	629,428	10	62,210	44,382	134,492	13,293	2
3	7	EMP. BEN.-GEN. SERV.	PATIENT DAYS	629,428	10	6,878		134,492	1,470	3
4	10	NURSING	PATIENT DAYS	629,428	10	187,368	187,368	134,492	40,036	4
5	15	EMP. BEN.-H.C.	PATIENT DAYS	629,428	10	34,893		134,492	7,456	5
6	17	ADMINISTRATIVE	PATIENT DAYS	629,428	10	77,349	77,349	134,492	16,527	6
7	19	PROFESSIONAL FEES	PATIENT DAYS	629,428	10	67,899		134,492	14,508	7
8	20	FEES,SUBSCRIPTIONS	PATIENT DAYS	629,428	10	1,658		134,492	354	8
9	21	CLERICAL & GENERAL	PATIENT DAYS	629,428	10	263,413	213,455	134,492	56,284	9
10	24	EDUCATION & SEMINAR	PATIENT DAYS	629,428	10	2,720		134,492	581	10
11	25	OTHER ADMIN. STAFF TRANS	PATIENT DAYS	629,428	10	29,820		134,492	6,372	11
12	26	INSURANCE	PATIENT DAYS	629,428	10	6,309		134,492	1,348	12
13	27	EMP. BEN.-GEN. ADMIN.	PATIENT DAYS	629,428	10	81,605		134,492	17,437	13
14	30	DEPRECIATION	PATIENT DAYS	629,428	10	37,059		134,492	7,919	14
15	32	INTEREST	PATIENT DAYS	629,428	10	34,524		134,492	7,377	15
16	33	REAL ESTATE TAXES	PATIENT DAYS	629,428	10	28,776		134,492	6,149	16
17	35	EQUIPMENT RENTAL	PATIENT DAYS	629,428	10	46,289		134,492	9,891	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 981,450	$ 522,555		$ 209,711	25

Facility Name & ID Number ALBANY CARE INC # 0037762 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: S.I.R. MANAGEMENT, INC.
Street Address: 6840 N. LINCOLN
City / State / Zip Code: LINCOLNWOOD, IL. 60712
Phone Number: (847) 675 -7979
Fax Number: (847) 675 -0555

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	DIETARY SALARIES	PATIENT DAYS	629,428	10	$ 54,767	$ 54,767	134,492	$ 11,702	1
2	7	EMP. BEN.-DIETARY	PATIENT DAYS	629,428	10	10,305		134,492	2,202	2
3	17	ADMIN./LEGAL SALARIES	PATIENT DAYS	629,428	10	635,411	635,411	134,492	135,770	3
4	19	FINANCIAL CONSULTANT	PATIENT DAYS	629,428	10	129,159		134,492	27,598	4
5	27	EMP. BEN.-ADMINISTRATIVE	PATIENT DAYS	629,428	10	$ 115,229	$	134,492	$ 24,621	5
6										6
7										7
8	10A	SPECIAL REHAB	SPECIAL REHAB INC.	82,944	4	58,457	58,457	37,032	26,099	8
9	15	EMP. BEN.-HEALTH CARE & P	SPECIAL REHAB INC.	82,944	4	$ 11,413	$	37,032	$ 5,095	9
10										10
11										11
12	6	REPAIRS AND MAINT.	MAINTENANCE INC.	221,184	10	145,348	145,348	11,808	7,759	12
13	7	EMP. BEN.-GEN. SERV.	MAINTENANCE INC.	221,184	10	$ 28,377	$	11,808	$ 1,515	13
14										14
15										15
16	1	DIETICIAN SALARIES	DIETICIAN SERVICE INC.	125,400	10	70,679	70,679	21,600	12,174	16
17	7	EMP. BEN.-GEN. ADMIN.	DIETICIAN SERVICE INC.	125,400	10	13,799		21,600	2,377	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,272,944	$ 964,662		$ 256,912	25

Facility Name & ID Number ALBANY CARE INC # 0037762 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CCS EMPLOYEE BENEFITS GROUP, INC.
Street Address: 4101 W. MAIN ST.
City / State / Zip Code: SKOKIE, IL 60076
Phone Number: (847) 674-1180
Fax Number: (847) 673-7741

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	22	EMPLOYEE HEALTH INS.	DIRECT ALLOCATION			$	$		$ 101,091	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 101,091	25

Facility Name & ID Number ALBANY CARE INC # 0037762 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: ECM OWNERS COUNCIL
Street Address: 6840 N. LINCOLN
City / State / Zip Code: LINCOLNWOOD, IL. 60646
Phone Number: (847) 676-2026
Fax Number: ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	19	PROFESSIONAL FEES	ECMOC MGMNT FEE INC.	96,000	9	$ 430	$	15,600	$ 70	1
2	20	DUES, FEES & SUBSCRIPTION	ECMOC MGMNT FEE INC.	96,000	9	264		15,600	43	2
3	21	CLERICAL	ECMOC MGMNT FEE INC.	96,000	9	400		15,600	65	3
4	26	INSURANCE	ECMOC MGMNT FEE INC.	96,000	9	813		15,600	132	4
5	35	VEHICLE RENTAL	ECMOC MGMNT FEE INC.	96,000	9	6,493		15,600	1,055	5
6	17	MANAGEMENT FEES	ECMOC MGMNT FEE INC.	96,000	9			15,600		6
7	17	ADMIN. SAL. - M. GIANNINI	ADMIN. HOURS	39	9	79,839	79,839	9	17,459	7
8	27	EMP. BEN. - M. GIANNINI	ADMIN. HOURS	39	9	4,713		9	1,031	8
9	17	ADMIN. SALARY	DIRECT ALLOCATION		6	(539)			13	9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 92,413	$ 79,839		$ 19,868	25

Facility Name & ID Number ALBANY CARE INC # 0037762 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number ALBANY CARE INC # 0037762 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number ALBANY CARE INC # 0037762 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number ALBANY CARE INC # 0037762 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number ALBANY CARE INC # 0037762 Report Period Beginning: 01/01/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	Nomura		X	Mortgage	$103,874	11/20/95	$ 12,500,000	$ 11,549,381	12/1/20	8.88%	$ 1,048,250	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Horton Insurance Agency		X	Insurance	$279	1/4/00					1,989	6
7	CIB Bank		X	Working Capital	None	6/20/01	1,200,000	1,200,000	6/20/02	prime-.25%	34,451	7
8	CIB Bank		X	Improvements	$271			250,000		6.50%	271	8
9	TOTAL Facility Related				$104,424		$ 13,700,000	$ 12,999,381			$ 1,084,961	9
	B. Non-Facility Related*											
10	See Supplemental Schedule										9,247	10
11	Interest income										(9,865)	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (618)	14
15	TOTALS (line 9+line14)						$ 13,700,000	$ 12,999,381			$ 1,084,343	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number ALBANY CARE INC # 0037762 Report Period Beginning: 01/01/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
1	Allocated from Preferred Bkkp	X					$	$			$ 1,870	1
2	Allocated from S.I.R. Mgmt	X									7,377	2
3												3
4												4
5												5
6												6
7												7
8												8
9												9
10												10
11												11
12												12
13												13
14												14
15												15
16												16
17												17
18												18
19												19
20												20
21							$	$			$ 9,247	21

Facility Name & ID Number ALBANY CARE INC # 0037762 Report Period Beginning: 01/01/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2000 report.	$	463,500	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	466,405	2
3. Under or (over) accrual (line 2 minus line 1).	$	2,905	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)	$	470,400	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$	19,504	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ 58,512 For 19 95-97 Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	492,809	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1996	440,157	8
	1997	447,385	9
	1998	439,710	10
	1999	449,196	11
	2000	457,691	12

Refund not offset against expense in current year, since it was for a period not used to set rates.
Allocated from S.I.R. Properties=$2,565; Allocated from S.I.R. Management=$6,149;
2001 accrual = $457,691 x 1.0277 = $457,400 (rounded)

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2000	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME ALBANY CARE INC COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0037762

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	11-19-121-019	Long term care property	$ 457,691.87	$ 457,691.87
2.	See attached	S.I.R. Management allocation	$ 64,023.00	$ 8,962.49
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 521,714.87	$ 466,654.36

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? X YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number ALBANY CARE INC # 0037762 Report Period Beginning: 01/01/01 Ending: 12/31/01

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 211,753 B. General Construction Type: Exterior Brick Frame _____ Number of Stories 7

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	24,573	1991	$ 84,558	1
2					2
3	TOTALS	24,573		$ 84,558	3

Facility Name & ID Number ALBANY CARE INC # 0037762 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4			1991	1991	$ 7,267,981	$ 230,730	35	$ 207,657	$ (23,073)	$ 3,071,638	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1993	61,428		20	3,194	3,194	26,741	9
10	Various			1994	120,534		20	6,026	6,026	44,381	10
11	Various			1995	291,499		20	14,331	14,331	92,624	11
12	Various			1996	58,666		20	2,934	(2,934)	16,192	12
13	Various			1997	72,445		20	3,740	3,740	15,923	13
14								-		-	14
15								-		-	15
16								-		-	16
17								-		-	17
18								-		-	18
19								-		-	19
20								-		-	20
21								-		-	21
22								-		-	22
23								-		-	23
24								-		-	24
25								-		-	25
26								-		-	26
27								-		-	27
28								-		-	28
29								-		-	29
30								-		-	30
31								-		-	31
32								-		-	32
33								-		-	33
34								-		-	34
35								-		-	35
36								-		-	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number ALBANY CARE INC # 0037762 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$ -	$	$ -	37
38						-		-	38
39						-		-	39
40						-		-	40
41						-		-	41
42						-		-	42
43						-		-	43
44						-		-	44
45						-		-	45
46						-		-	46
47						-		-	47
48						-		-	48
49						-		-	49
50						-		-	50
51						-		-	51
52						-		-	52
53						-		-	53
54						-		-	54
55						-		-	55
56						-		-	56
57						-		-	57
58						-		-	58
59						-		-	59
60						-		-	60
61						-		-	61
62						-		-	62
63						-		-	63
64						-		-	64
65						-		-	65
66						-		-	66
67						-		-	67
68	Related Party Allocations (Page 12-REP & Page 12A-REP)		217,835	9,424		10,748	1,324	55,342	68
69	Financial Statement Depreciation			96,734			(96,734)		69
70	TOTAL (lines 4 thru 69)		$ 8,090,388	$ 336,888		$ 248,630	$ (94,126)	$ 3,322,841	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ALBANY CARE INC # 0037762 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 8,090,388	$ 336,888		$ 248,630	$ (88,258)	$ 3,322,841	1
2	BATHROOM RENOVATION	1998	6,941		20	347	347	1,388	2
3	GENERATOR	1998	25,000		20	1,250	1,250	4,583	3
4	METROM CONSTR.	1998	101,229		20	5,061	5,061	18,979	4
5	FIRE DAMPERS	1998	8,633		20	432	432	1,476	5
6	FIRE DOORS (7)	1998	8,976		20	449	449	1,759	6
7	BATHROOM WORK	1998	1,830		20	92	92	330	7
8	PASSENGER ELEVATOR	1998	2,900		20	145	145	520	8
9	ELECTRICAL WORK	1998	5,169		20	258	258	925	9
10	ADD'L FIRE DAMPERS	1998	1,957		20	98	98	302	10
11	WATER TANK	1998	3,883		20	194	194	711	11
12	COMPRESSOR	1998	2,934		20	147	147	527	12
13	CARPETING	1998	1,195		20	60	60	220	13
14	BLINDS	1998	4,247		20	212	212	760	14
15	BOILER WORK	1998	2,322		20	116	116	377	15
16	CARPETING	1999	16,541		20	827	827	2,481	16
17	HOT WATER TANK	1999	5,150		20	258	258	753	17
18	ELEVATOR WORK	1999	5,062		20	253	253	717	18
19	PHONE EQUIP	1999	3,171		20	159	159	437	19
20	PHONE EQUIP	1999	471		20	24	24	64	20
21	SIR REMODELING	1999	23,330		20	1,167	1,167	2,626	21
22	FIRE ALARM SYSTEM	1999	173,676		20	8,684	8,684	18,092	22
23	HOT WATER FLOW	1999	6,485		20	324	324	756	23
24	ELEVATOR WORK	1999	5,062		20	253	253	717	24
25	FLOORING	1999	3,880		20	194	194	404	25
26	NEW FRNT DOORS	1999	2,185		20	109	109	236	26
27	NEW PEDESTRIAN DOOR	1999	1,875		20	94	94	204	27
28	ELECTRICAL WIRING	1999	2,063		20	103	103	275	28
29	BASIN	1999	2,800		20	140	140	420	29
30	FIRE GRILLS &DAMPERS	1999	2,204		20	110	110	330	30
31	BLINDS	1999	723		20	36	36	108	31
32	SEWER PIPING	1999	1,400		20	70	70	204	32
33	PIPING	1999	2,150		20	108	108	297	33
34	TOTAL (lines 1 thru 33)		$ 8,525,832	$ 336,888		$ 270,404	$ (66,484)	$ 3,384,819	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ALBANY CARE INC # 0037762 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 8,525,832	$ 336,888		$ 270,404	$ (66,484)	$ 3,384,819	1
2	PAINTING	1999	1,200		20	60	60	175	2
3	PAINTING &DECORATING	1999	818		20	41	41	109	3
4	DOOR	1999	1,588		20	79	79	211	4
5	STAIRWAY	1999	600		20	30	30	68	5
6	NURSE CALL SYSTEM	2000	5,611		20	281	281	562	6
7	ELEVATOR WORK	2000	3,750		20	188	188	376	7
8	ELEVATOR WORK	2000	3,650		20	183	183	366	8
9	HVAC WORK	2000	4,344		20	217	217	307	9
10	FLOORING	2000	2,110		20	106	106	203	10
11	ROOFING	2000	129,494		20	6,475	6,475	8,094	11
12	LIGHT FIXTURES	2000	7,404		20	740	740	802	12
13	DINING ROOM FLOOR	2000	55,275		20	2,764	2,764	2,994	13
14	PAINTING	2000	16,595		20	830	830	899	14
15	KITCHEN COMPRESSOR	2000	2,307		20	115	115	173	15
16	CEILING TILES	2000	3,111		20	156	156	156	16
17	THERMOSTAT	2000	1,585		20	79	79	79	17
18	OVERHEAD GARAGE	2000	850		20	43	43	43	18
19	HEAT PUMP	2000	1,398		20	70	70	70	19
20	DOOR ALARM	2000	1,098		20	55	55	55	20
21	COMPRESSOR	2000	1,122		20	56	56	56	21
22	ELECTRICAL WORK	2001	6,335		20	317	317	317	22
23	LIGHTING	2001	3,530		20	177	177	177	23
24	HVAC WORK	2001	8,188		20	341	341	341	24
25	HVAC WORK	2001	7,275		20	303	303	303	25
26	BOILER	2001	206,552		20	6,885	6,885	6,885	26
27	ELEVATOR WORK	2001	14,500		20	242	242	242	27
28	BATHROOM HVAC	2001	4,394		20	37	37	37	28
29	SHOWER RENOVATION	2001	39,492		20	494	494	494	29
30	OVERHEAD GARAGE	2001	1,735		20	44	44	44	30
31	SEWER WORK	2001	1,725		20	43	43	43	31
32	BOILER WORK	2001	2,967		20	49	49	49	32
33	STAIRCASE	2001	2,860		20	143	143	143	33
34	TOTAL (lines 1 thru 33)		$ 9,069,295	$ 336,888		$ 292,047	$ (44,841)	$ 3,409,692	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ALBANY CARE INC # 0037762 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 9,069,295	$ 336,888		$ 292,047	$ (44,841)	$ 3,409,692	1
2	TILE FLOORING	2001	68,106		20	3,405	3,405	3,405	2
3	BATHROOM WORK	2001	3,222		20	161	161	161	3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 9,140,623	$ 336,888		$ 295,613	$ (41,275)	$ 3,413,258	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ALBANY CARE INC # 0037762 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 9,140,623	$ 336,888		$ 295,613	$ (41,275)	$ 3,413,258	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 9,140,623	$ 336,888		$ 295,613	$ (41,275)	$ 3,413,258	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ALBANY CARE INC # 0037762 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		$ 9,140,623	$ 336,888		$ 295,613	$ (41,275)	$ 3,413,258	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
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16									16
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18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 9,140,623	$ 336,888		$ 295,613	$ (41,275)	$ 3,413,258	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ALBANY CARE INC # 0037762 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$ 9,140,623	$ 336,888		$ 295,613	$ (41,275)	$ 3,413,258	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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22									22
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 9,140,623	$ 336,888		$ 295,613	$ (41,275)	$ 3,413,258	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ALBANY CARE INC # 0037762 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		$ 9,140,623	$ 336,888		$ 295,613	$ (41,275)	$ 3,413,258	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 9,140,623	$ 336,888		$ 295,613	$ (41,275)	$ 3,413,258	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ALBANY CARE INC # 0037762 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 9,140,623	$ 336,888		$ 295,613	$ (41,275)	$ 3,413,258	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 9,140,623	$ 336,888		$ 295,613	$ (41,275)	$ 3,413,258	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ALBANY CARE INC # 0037762 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4			1993		$ 23,818	$ 756	35	$ 681	$ (75)	$ 5,784	4
5			1993		57,096	1,813	35	1,631	(182)	13,866	5
6											6
7											7
8											8
	Improvement Type**										
9	Albany Ltd. Partnership-Land Improvement			1993	58,478	3,453	20	4,500	1,047		9
10	Allocated from Preferred Bookkeeping			1997	29,745	666	20	1,487	821	7,152	10
11	Allocated from Preferred Bookkeeping			1999	236	45	20	12	(33)	30	11
12	Allocated from Preferred Bookkeeping			2000	1,492	-	20	75	(75)	106	12
13											13
14										13,866	14
15	Allocated from S.I.R. Properties-S.I.R. Management			1999	7,235	723	20	362	(361)	904	15
16	Allocated from S.I.R. Properties-S.I.R. Management			1998	3,457	346	20	173	(173)	605	16
17	Allocated from S.I.R. Properties-S.I.R. Management			1997	215	22	20	11	(11)	59	17
18	Allocated from S.I.R. Properties-S.I.R. Management			1994	544	14	20	27	13	204	18
19	Allocated from S.I.R. Properties-S.I.R. Management			1993	926	25	20	46	21	394	19
20											20
21	Allocated from S.I.R. Management			1993	24,522	683	20	1,237	554	10,902	21
22	Allocated from S.I.R. Management			1994	76	-	20	8	8	56	22
23	Allocated from S.I.R. Management			1995	560	-	20	28	28	180	23
24	Allocated from S.I.R. Management			1999	2,664	126	20	133	7	195	24
25	Allocated from S.I.R. Management			2000	1,608	280	20	80	(200)	136	25
26											26
27	Allocated from S.I.R. Management-Preferred Bookkeeping			1999	3,018	302	20	151	(151)	377	27
28	Allocated from S.I.R. Management-Preferred Bookkeeping			1998	1,442	144	20	72	(72)	252	28
29	Allocated from S.I.R. Management-Preferred Bookkeeping			1997	90	9	20	4	(5)	25	29
30	Allocated from S.I.R. Management-Preferred Bookkeeping			1994	227	6	20	11	5	85	30
31	Allocated from S.I.R. Management-Preferred Bookkeeping			1993	386	11	20	19	8	164	31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A-REP, Line 70 for total

Facility Name & ID Number ALBANY CARE INC # 0037762 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
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62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 217,835	$ 9,424		$ 10,748	$ 1,174	$ 55,342	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ALBANY CARE INC # 0037762 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 515,941	$ 6,164	$ 50,457	$ 44,293	10	$ 343,329	71
72	Current Year Purchases	91,579		2,688	2,688	10	2,688	72
73	Fully Depreciated Assets	624,611				10	624,611	73
74								74
75	TOTALS	$ 1,232,131	$ 6,164	$ 53,145	$ 46,981		$ 970,628	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 10,457,312	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 343,052	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 348,758	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 5,706	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 4,383,886	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number ALBANY CARE INC # 0037762 Report Period Beginning: 01/01/01 Ending: 12/31/01

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☒ X NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2002	$
13.	/2003	$
14.	/2004	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ X NO

16. Rental Amount for movable equipment: $ 10,499 Description: See attached schedule
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Facility	1997 Chevy Omni	$ 354	$ 3,844	17
18	Facility	2000 Ford	517	6,248	18
19	Allocation from Preferred/SIR/ECM			13,711	19
20					20
21	TOTAL		$ 871	$ 23,803	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number ALBANY CARE INC # 0037762 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

			1	2	3	4
			Facility			
			Drop-outs	Completed	Contract	Total
1	Community College Tuition		$	$	$	$
2	Books and Supplies					
3	Classroom Wages	(a)				
4	Clinical Wages	(b)				
5	In-House Trainer Wages	(c)				
6	Transportation					
7	Contractual Payments					
8	Nurse Aide Competency Tests					
9	TOTALS		$	$	$	$
10	SUM OF line 9, col. 1 and 2	(e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number ALBANY CARE INC # 0037762 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number ALBANY CARE INC # 0037762 Report Period Beginning: 01/01/01 Ending: 12/31/01

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/01 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 27,793	$ 37,207	1
2	Cash-Patient Deposits	34,126	34,126	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,271,058	2,741,458	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	20,073	20,073	6
7	Other Prepaid Expenses	4,177	4,177	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See supplemental schedule	160,557	160,557	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,517,784	$ 2,997,598	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		143,036	13
14	Buildings, at Historical Cost		7,267,981	14
15	Leasehold Improvements, at Historical Cost	1,244,779	1,244,779	15
16	Equipment, at Historical Cost	1,368,311	1,368,311	16
17	Accumulated Depreciation (book methods)	(1,301,551)	(3,673,725)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See supplemental schedule	372,693	488,749	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,684,232	$ 6,839,131	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,202,016	$ 9,836,729	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 244,614	$ 244,615	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	47,678	47,678	28
29	Short-Term Notes Payable	1,450,000	1,450,000	29
30	Accrued Salaries Payable	327,420	327,420	30
31	Accrued Taxes Payable (excluding real estate taxes)	18,623	489,023	31
32	Accrued Real Estate Taxes(Sch.IX-B)	470,400	470,400	32
33	Accrued Interest Payable	2,250	62,076	33
34	Deferred Compensation			34
35	Federal and State Income Taxes	43,000	43,000	35
	Other Current Liabilities(specify):			
36	See supplemental schedule			36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,603,985	$ 3,134,212	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		11,549,381	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See supplemental schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 11,549,381	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,603,985	$ 14,683,593	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,598,031	$ (4,846,864)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,202,016	$ 9,836,729	48

*(See instructions.)

Facility Name & ID Number ALBANY CARE INC # 0037762 Report Period Beginning: 01/01/01 Ending: 12/31/01

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,881,554	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,881,554	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	2,051,677	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(2,335,200)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (283,523)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,598,031	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number ALBANY CARE INC # 0037762 Report Period Beginning: 01/01/01 Ending: 12/31/01

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 11,881,587	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 11,881,587	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	9,865	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 9,865	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See supplemental schedule	62,819	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 62,819	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 11,954,271	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,588,164	31
32	Health Care	3,171,589	32
33	General Administration	2,547,524	33
	B. Capital Expense		
34	Ownership	2,367,010	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	228,307	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 9,902,594	40
41	**Income before Income Taxes (line 30 minus line 40)****	2,051,677	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 2,051,677	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Cash basis If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number ALBANY CARE INC # 0037762 Report Period Beginning: 01/01/01 Ending: 12/31/01

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,845	2,086	$ 95,388	$ 45.73	1
2	Assistant Director of Nursing	4,036	4,522	91,446	20.22	2
3	Registered Nurses	2,292	2,458	55,155	22.44	3
4	Licensed Practical Nurses	37,744	40,092	732,738	18.28	4
5	Nurse Aides & Orderlies	106,189	111,893	931,269	8.32	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,089	3,252	41,180	12.66	8
9	Activity Director					9
10	Activity Assistants	48,238	51,571	426,111	8.26	10
11	Social Service Workers	31,016	33,559	436,380	13.00	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	24,448	26,630	251,889	9.46	15
16	Dishwashers					16
17	Maintenance Workers	5,443	5,801	60,244	10.39	17
18	Housekeepers	27,847	30,601	223,680	7.31	18
19	Laundry					19
20	Administrator	1,845	2,086	120,044	57.55	20
21	Assistant Administrator	1,028	1,075	22,444	20.88	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	27,998	30,188	299,913	9.93	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	7,085	7,749	113,247	14.61	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	330,143	353,563	$ 3,901,128 *	$ 11.03	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	$ 21,600	01-03	35
36	Medical Director	Monthly	2,400	09-03	36
37	Medical Records Consultant	Monthly	4,032	10-03	37
38	Nurse Consultant	Monthly	82,572	10-03	38
39	Pharmacist Consultant	Monthly	1,800	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant	44	2,200	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47	Specialized rehab consultant	5,822	37,032	10a-03	47
48	Food service consultant	4,123	42,540	01-03	48
49	TOTAL (lines 35 - 48)	9,989	$ 194,176		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides	3,109	60,149	10-03	52
53	TOTAL (lines 50 - 52)	3,109	$ 60,149		53

Facility Name & ID Number ALBANY CARE INC # 0037762 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Dennis Tossi	Administrator	48%	$ 120,244
Leif Woodhouse (3/5/01-5/7/01)	Asst. Administrator	0	16,055
Elizabeth Salazar (10/1-12/31/01)	Asst. Administrator	0	6,189
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 142,488

B. Administrative - Other

Description	Amount
Director of Administrative Services-S.I.R. Management	$ 52,548
Directors Fees-S.I.R. Management	90,125
Management fees-S.I.R. Management	696,881
Owners council-Extended Care Management	15,600
TOTAL (agree to Schedule V, line 17, col. 3)	$ 855,154
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
See attached schedule	Legal	$ 66,129
Frost Ruttenberg & Rothblatt	Accounting	12,703
Preferred bookkeeping	Accounting	20,600
Personnel Planners	Unemployment consultant	8,492
Preferred bookkeeping	Computer services	10,008
S.I.R. Management	Director of Regulatory Services	32,487
Preferred bookkeeping	Bookkeeping services	125,100
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 275,519

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 35,357
Unemployment Compensation Insurance	24,881
FICA Taxes	288,626
Employee Health Insurance	75,212
Employee Meals	14,892
Illinois Municipal Retirement Fund (IMRF)*	
Union health and welfare	106,412
401k contributions	10,146
Employee benefits	10,133
TOTAL (agree to Schedule V, line 22, col.8)	$ 565,659

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 400
Advertising: Employee Recruitment	
Health Care Worker Background Check	1,293
(Indicate # of checks performed 108)	
Classified advertising	21,557
Advertising and promotions	3,599
Dues and subscriptions	18,044
Licenses and fees	19,012
Yellow page advertising	342
Allocation from SIR/Preferred/ECM	530
Less: Public Relations Expense	
Non-allowable advertising	(3,599)
Yellow page advertising	(342)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 60,836

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	1,547
Allocation from S.I.R Management	581
Allocation from Preferred	191
Entertainment Expense	
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,319

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number ALBANY CARE INC # 0037762 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
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16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number ALBANY CARE INC # 0037762 Report Period Beginning: 01/01/01 Ending: 12/31/01

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **Yes**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Illinois Council on LTC $26,740**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **175** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? _____ YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **228,307**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **14,892** Has any meal income been offset against related costs? **No** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **100%**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **No**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **Yes**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **No** If no, please explain. _____

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees